PATIENT REFERRAL FORM

PHONE: 805-505-9955
FAX: 805-505-9956
E-MAIL: INFO@ADVANCEDCARE-HH.COM

PATIENT INFORMATION

Patient Name: ______________________________ DOB: ______________________________

Address: ____

Phone #: ______________________________ Emergency Phone #: ______________________

SS#: ____________________________________

Insurance: ☐ Medicare ☐ Medi-Cal ☐ Other ID #: ______________________________

Diagnosis: ____

I CERTIFY THAT BASED ON MY CLINICAL FINDINGS, THE FOLLOWING SERVICES ARE MEDICALLY NECESSARY:

☐ RN ☐ PT ☐ OT ☐ SLP ☐ MSW ☐ HHA

☐ Alzheimer's	☐ COPD	☐ Falls	☐ Pressure Ulcers
☐ ALS	☐ CVA / Stroke	☐ HTN	☐ Stasis Ulcers
☐ Asthma	☐ Cancer	☐ HIV / AIDS	☐ Wounds/Lesions
☐ CHF	☐ Diabetes	☐ Joint Replacement	☐ Ostomy
☐ CKD	☐ Dementia	☐ Spine Surgery	☐ Vision Impairments
☐ Catheter	☐ Depression	☐ Ostomy	☐ Other ______________

NOTES/INSTRUCTIONS:

____

____

____

____

____

PLEASE SEND SUPPORTING DOCS: DEMOGRAPHICS / H&P / RECENT PROGRESS NOTES

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter with this patient that meets the physicians face-to-face encounter requirements with this patient (must be 90 days prior to or 30 days after start of home health services)

Face-Face Date: ______________________________ Homebound: ☐ YES

X Physician Signature: ______________________________ Date: ____________________

Physician Name: ____

Phone #: ______________________________ Fax: ______________________________

FAX TO: (805) 505-9956 / PHONE: (805) 505-9955